Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

October 3, 2014

Ms. Tasha Thomas, Administrator
The Residence At Otter Creek
350 Lodge Road
Middlebury, VT 05753-4498

Dear Ms. Thomas:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 28, 2014.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:jl

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1008	A. BUILDING: _____ B. WING _____	C 08/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT OTTER CREEK	350 LODGE ROAD MIDDLEBURY, VT 05753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An on-site survey to investigate a complaint and a facility self-report was completed by the Division of Licensing and Protection on 8/28/14. The following regulatory violations were found related to both reports.	R100	See attached plans of correction.	
R126 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assure that necessary care was provided to meet the resident's psychosocial, nursing and medical needs for 2 of 5 residents in the total sample. (Residents #1, #2). Findings include: 1. Per interviews with a resident's family member on 8/26/14 and 8/27/14, Resident #1 had caused anxiety and emotional distress to Resident #2 by assaulting the resident on at least 2 occasions and wandering intrusively into Resident #2's room on multiple occasions. The facility failed to provide adequate monitoring and supervision of Resident #1 to prevent further assaultive attacks on others after the first type of this attack on another resident occurred on January 13, 2014. Resident #1 had a history of striking other residents and staff totally unprovoked and without	R126		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: RN — (X6) DATE: 9/22/14

STATE FORM 6899 2Q8J11 If continuation sheet 1 of 13

Revised — 10/1/14

R126, R145, R150, R162, R167, R200, R224 + R266 POCs accepted 10/2/14 MBolton RN/PMC

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R126	Continued From page 1 warning. During the period from 1/13/14 - 7/13/14, Resident #1 physically struck 4 other resident's of the SCU. One of these resident was struck on 2 occasions and stated that he/she felt targeted by Resident #1, per telephone interview with the resident's family member on 8/26/14. When interviewed on 8/27/14, Resident #2 told the surveyor that he/she was upset that Resident #1 used to come into his/her room anytime and that the facility didn't do much to stop it. A Velcro stop sign was placed over the door but Resident #1 used to go under it at times and continued to enter the room. This caused anxiety and stress for Resident #2. Two nursing staff interviewed stated that Resident #1 was not always deterred by the use of the Velcro stop signs and wandered into other resident's rooms at will. Refer also to R-224 2. Per review of the medical record and incident reports for Resident #1, and confirmed during interviews with nursing staff on 8/28/14, Resident #1 was frequently physically assaultive towards staff and received skin tears during the shower process on 1/11/14 and 5/7/14. During the shower on 1/11/14, the resident sustained a skin tear on the right arm above the elbow. the incident report stated, 'resident was yelling and swinging at staff'. On 5/7/14, the resident was very combative during the shower and sustained a skin tear on the right arm and eye. The RN was asked if they had tried to give a different type of bathing process for this resident, who clearly did not like the showering process, the RN said a bed bath had been tried and was not very successful either. When asked about using one of the newer type of bath in a bag processes, the RN said they had not tried that method. Although the resident was almost always resistive to personal care, staff failed to identify possible care plan strategies	R126		

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R126	Continued From page 2 to change the process to enhance the resident's comfort and decrease their anxiety over the showering process.	R126		
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN failed to assure that resident care plans addressed each resident's identified needs, including necessary care and and specific interventions, for 3 of 4 residents in the targeted sample. (Residents #1, #2 and #3). Findings include: 1. Per record review and confirmed during interview with the Charge Nurse (Licensed Practical Nurse, LPN) on duty on 8/28/14 at 11:30 AM, and Registered Nurse (RN) at 5:45 PM, Resident #1's care plan did not address the following current care needs: the resident's history of assaultive behaviors over a 6 month period, where he/she would strike other resident's unprovoked, was not included on the care plan addressing behaviors and agitation. Three residents were struck by this resident, in four separate incidents since mid January, 2014. The interventions on the care plan were not sufficient	R145		

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R145	Continued From page 3 to prevent these unprovoked attacks and the resident lacked adequate staff supervision to prevent the incidents from happening. For the area of assistance with bathing, staff interviewed during the 2 days of survey indicated that the resident was very combative with showers and frequently hit staff present attempting to wash the resident. During interview with the RN, they had not had a trial of utilizing a bedside bathing system to reduce the incidence of resident to staff incidents, and decrease the resident's level of agitation. In the area of psychotropic medication for agitated behavior management, the facility tried only PRN Haldol, which did not appear to effectively treat the dangerous impulsive aggressive actions towards other resident and staff. There was not evidence in the medical record and from staff interviews throughout the survey that there were trials of any other medications or consults for psychological services ordered for this resident. 2. Per record review and confirmed during interview with the LPN and a caregiver at 1:45 PM on 8/28/14, Resident #2's care plan did not address the resident's use of antipsychotic medication to manage disinhibited sexual behaviors towards staff and other residents. The resident is at risk for falls and also had a history of a fall and the care plan was not revised to reflect this need. 3. Per record review and confirmed during interview with the LPN at 1:45 PM on 8/28/14, Resident #3's care plan failed to address that the resident was on Hospice services, and that the resident receives the antipsychotic medication	R145		

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R145	Continued From page 4 Haldol for repetitive, loud, calling out behaviors that are not redirectable by staff interventions.	R145		
R150 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (7) Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, nursing staff failed to assure that resident changes in condition and/or incidents and accident were recorded in the medical record at the time of the occurrence for 3 of 3 applicable residents. (Residents #1, #2 and #3). Findings include: 1. Per record review and confirmed during interview with the RN on 8/27/14 at 4 PM, there was no progress note on Resident #3's medical record regarding an incident on 7/13/14 where Resident #1 hit Resident #3 on the shoulder without provocation. The Resident #3, who was on hospice, was resting in the recliner in the living area at the time of the incident. Resident#1 walked over to where she/he was and told him/her to 'get up'; when they did not 'get up', Resident #1 'hit him/her on the left shoulder'. Per review of the incident report dated 7/13/14, the report was incomplete and failed to describe any assessment of Resident #3 and any notification of the incident to either residents' family and the MD(s).	R150		

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R150	Continued From page 5 2. Per record review on 8/27/14 and confirmed during interview with the RN staff nurse on 8/28/14 at 2 PM, Resident #1 was found with open wounds (2) on 1/12/14 on the upper right arm and there was no evidence that family and MD had been notified of these injuries of unknown origin. On 3/7/14, the resident was found on the floor at 0100 and there was no evidence of family notification of the event. 3. Per record review and confirmed during LPN interview 8/28/14 at 11:26 AM, staff failed to document in the medical record an event occurring on 7/8/14, when Resident #1 struck Resident #2 without provocation. Although staff completed an incident report, there was no record of the assault in Resident #2's medical record. 4. Per a note dated 3/25/14, Resident #3 was noted to be "profoundly dehydrated" per a physician call to the facility, based on lab results ordered for a suspected urinary tract infection. The physician gave orders noted as "PCP requests 2 pints liquid before noon and 2 pints of liquid between noon and supper for 5 days". The note continued to say "Staff advised". Per review of the documentation, including the MARs, there was no evidence of staff transcription of the order to the MAR. The MAR stated "4 oz. fluid 8 x daily", which equals 32 oz total per day. This is less volume than the new orders of 3/25/14, which totals 64 oz daily. When the nurse was asked how they assured that the resident received the ordered fluids, she was not aware of any tracking method used to note completion of the physician orders.	R150		
R182 SS=D	V. RESIDENT CARE AND HOME SERVICES	R162		

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R162	Continued From page 6 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that each resident's medication regime included a diagnosis for each medication ordered by the physician for 1 of 3 residents in the targeted sample. (Resident #3). Findings include: Per record review on 8/28/14, Resident #3 received Trazadone, an antidepressant medication daily and there was no diagnosis found in the medical record to support the use of this medication. The lack of the required diagnosis was confirmed during interview with the RN at 5:45 PM the same day.	R162		
R167 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific	R167		

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R167	Continued From page 7 behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on staff interview and record reviews, the RN failed to develop a PRN care plan to direct unlicensed staff in the administration of PRN psychoactive medication that included all of the required regulatory components for 1 applicable resident in the sample, (Resident #1) findings include: Per record review and confirmed during interview with the RN Charge Nurse on duty on 8/27/14 at 11:00 AM, the 'Plan for the use of a PRN Psychoactive Medication', used to direct unlicensed nursing staff in the administration of psychotropic medication administration on an 'as needed' basis, failed to describe the specific behaviors the medication was intended to correct and failed to specify the circumstances that indicate the use of the medication. The facility's use of a PRN Care Plan is generic and not specific to each resident's targeted behaviors warranting the use of this type of medication, which potentially has significant, harmful side effects. The medication ordered as PRN (as needed) by the physician was Haldol, a powerful anti-psychotic medication. The Plan stated "Reason for prescription; Anxiety. This medication will be used to treat the following behaviors: "Anxiety, as exhibited by restless, not able to engage for more than a couple of minutes, unable to remain seated for more than a	R167		

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R167	Continued From page 8 couple of minutes, and confusion". These are not behaviors warranting the use of an antipsychotic medication. Per review of the medical record, the resident did have a history of impulsive, assaultive behaviors towards other residents and staff, and this behavior was not described on the plan. The PRN plan as written was not individualized for this resident and failed to describe the specific circumstances that indicate when staff should administer the medication.	R167		
R200 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to produce a written policy/procedure to direct staff in the completion of the incident report process, regarding incidents reviewed for 5 of 5 applicable residents. (Residents #1,2,3, 4 and 5) Findings include: Per review of multiple incident reports (reviewed 8/27/14 - 8/28/14) regarding resident to resident assaults and resident to staff assaults, as well as injuries of unknown origin and falls reports, staff failed to completely document the reports and there was no evidence of post incident assessments and family/MD notifications in most of the examples reviewed. This was confirmed Administrator of the home an the RN at 5:15 PM.	R200		

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R200	Continued From page 9 on 8/28/14.	R200		
R224 SS=E	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that each resident's right to be free from abuse was protected, based on unprovoked acts of physical aggression by 1 former resident of the SCU. (Residents #1 and 2). Findings include: Per interviews with a resident's family member on 8/26/14 and 8/27/14, Resident #1 (now deceased) had caused anxiety and emotional distress to Resident #2 by assaulting the resident on at least 2 occasions and wandering intrusively into Resident #2's room. The facility failed to provide adequate monitoring and supervision of Resident #1 to prevent further assaultive attacks on others after the first type of this attack on another resident occurred on January 13, 2014. Resident #1 had a history of striking other residents and staff totally unprovoked and without warning. During the period from 1/13/14 - 7/13/14, Resident #1 physically struck 4 resident's of the SCU,; one of these residents was struck on 2 occasions and stated that he/she felt targeted by Resident #1 during interview with the resident's family member on 8/26/14 via	R224		

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R224	Continued From page 10 telephone. When interviewed on 8/27/14 in person, Resident #2 told the surveyor that he/she was upset that Resident #1 used to come into his/her room anytime and that the facility didn't do much to stop it. A Velcro stop sign was placed over the door but Resident #1 used to go under it at times and continued to enter the room at times. Staff placed another Velcro sign across the door but this also did not consistently work. This caused anxiety and stress for Resident #2. Two nursing staff interviewed stated that Resident #1 was not always deterred by the use of the Velcro stop signs and wandered into other resident's rooms at will. Staff confirmed that Resident #1 was difficult to redirect at times and had periods of physically aggressive acts toward staff and other residents. Per review of the care plan for this resident regarding these behaviors, the care plan stated: "If strategies are not working, leave resident and reapproach in 30 minutes", " if resident has wandered into another resident's room and redirection was unsuccessful, remove the other resident and allow [the resident] time by himself, reapproach in 15 minutes." Most of the interventions in the care plan were reactive, and not proactive, to keep all of the residents safe on the unit. A lack of adequate supervision and monitoring was not provided to help prevent these abusive actions towards other residents and staff. Refer also to R-126	R224		
R266 SS=F	IX. PHYSICAL PLANT 9.1 Environment	R266		

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R266	Continued From page 11 9.1,a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain a safe environment regarding protruding heating/cooling metal covers on the Special care Unit that were not maintained in good repair. Findings include: During a tour of the Special Care Unit (SCU) of the facility on 8/27/13 at 11 AM, it was observed that many of the heating/cooling unit covers, which protrude from the walls approximately 1.5 inches, were not securely closed, exposing extremely sharp metal clips inside the cover, posing a risk of injury to the residents with dementia residing on the SCU. In the common hallways where residents walk independently, only 1 of 4 covers was attached properly. One of the covers was bent and not closable, and the frame was pulled out from the wall. Staff stated on the afternoon of 8/27/14 that one of the residents had pulled the heater frame out of the wall some time ago. Per observations of the wall covers in the resident rooms, of the 18 rooms observed, only 4 covers were in proper working order. In room 144, the unit frame was also pulled out and not attached to the wall securely. In most of the cases, one of the clips was bent so that the covers would not attack securely. Per staff interviews that afternoon, there were 2 residents identified that had opened the loose covers. The open cover would expose electric switches and some dust laden air filters, as well as the sharp metal parts of the unit. The RN providing the initial unit tour agreed that the open covers exposed sharp metal parts, posing a safety risk.	R266		

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R266	Continued From page 12 to residents. During another tour of the unit the following day, the Director of Maintenance confirmed the safety risks posed by the unit covers as observed and a plan was developed to reduce the risk to residents.	R266		

The Residence at Otter Creek plan of correction

R126

Deficiency #1

5.5 General Care: 5.5.a: Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs.

Deficiency: "Based on interview and record review, the facility failed to assure that necessary care was provided to meet the resident's psychosocial, nursing and medical needs for 2 of 5 residents in total sample (Residents #1, #2).

#1 Action to correct deficiency: Behavior Management policy, Behavior Management Plan and Inappropriate Behaviors Policy created. See attached. Resident #1 has been discharged/deceased. Staff to be educated at Med Tech meeting and all staff meeting regarding strategies to manage difficult behaviors, as well as Behavior Management Plan and how best to care for a combative resident.

#2 Measures to assure this does not recur: Behavior Managements Plans to be created and utilized for any resident who displays inappropriate behaviors or requires a Behavior Management Plan This will ensure all residents in the community will have psychosocial, nursing and medical needs met. Care plans to be updated with completion of Behavior Management Plans to inform staff.

#3 How corrective action will be monitored: Behavior Management Plans to be monitored monthly times four months and subsequently it will be monitored quarterly by Health Services Director, when care plan review completed.

R145

Deficiency #2

5.9.c (2): "Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being"

Deficiency: "Based on staff interview and record review, the RN failed to assure that resident care plans addressed each residents identified needs, including necessary care and specific interventions, for 3 of 4 residents in the targeted sample"

#1: Action to correct deficiency: It was discussed at the nurse's meeting on 9/22/14, that care plans require updating with acute medical or psychological changes and behaviors. Care plans will be reviewed weekly, until all resident's care plans have

been reviewed by RN. Care plans will continue to be updated by an RN quarterly and as needed to meet residents changing needs, prompted by electronic medical record by RN and with care plan meetings bi-annually.

#2: Measures to assure that this does not occur: Continued follow up by licensed nurses as well as Health Services Director.

#3: How corrective action will be monitored: The Health Services Director will review the 72 hour communication report on electronic medical record regarding acute resident issues and ensure care plan has been updated by chart audit.

R150

Deficiency #3:

5.9c: "Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken."

Deficiency: "Based on staff interview and record review, nursing staff failed to assure that resident changes in condition and/or incidents and accident were recoded in the medical record at the times of occurrence for 3 out of 3 residents. (Residents #1, #2, and #3)."

#1: Action to correct deficiency: At nurse's meeting on 9/22/2014, it was discussed with all nurse's that every incident resulting in a change in condition, accident and/or incident report, requires a corresponding nurse's note completed within 24 hours, Any incident that is considered emergent and needs immediate medical attention, a nurses note will be completed at the time of occurrence. Medications Technicians (MT) were educated on 10/1/2014 at mandatory MT meeting, that incident reports must be completed at the time of occurrence, along with action taken and documentation of notifications, as well as any witness statements.

#2: Measures to assure this does not occur: Daily review completed by nursing staff of incident/accident reports. Along with daily review of 72 hour communication report (containing all nurse's notes completed in past 72 hours) by HSD, to ensure that nursing staff has completed appropriate documentation.

#3: How corrective action will be monitored: Daily review completed by nursing staff of incident/accident reports. Along with daily review of 72 hour communication report (containing all nurse's notes completed in past 72 hours) by HSD, to ensure that nursing staff has completed appropriate documentation. Incident reports to be discussed and reviewed at the Quality Improvement Meeting, held quarterly with Executive Director and HSD.

R162

Deficiency #4:

5.10.c: "Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the residents records".

Deficiency: "Based on staff interview and record review, the facility failed to assure that each resident's medication regime included a diagnosis for each medication ordered by the physician for 1 of 3 residents in the targeted sample (Resident #3)."

#1: Action to correct deficiency: Diagnosis added to chart for Resident #3's prescribed Trazadone after clarification from MD. On 9/17/2014, report was run on Point Click Care to determine all medications in resident's medication record, that do not have a diagnoses listed. Any medications without active diagnoses, primary MD will be updated to obtain these diagnoses. Point Click Care was updated to make it mandatory when entering physician's orders, for a diagnoses to be entered before order can be saved. At nurse's meeting on 9/22/14, all nurse's were made aware of the change.

#2: Measures to assure this does not occur: When entering physician's orders, Point Click Care, prompts nurse to enter diagnoses before order can be initiated and saved.

#3: How corrective action will be monitored: Quarterly, report will be run utilizing Point Click Care software, to evaluate current medications without diagnoses. This will be reviewed by HSD.

Deficiency #5:

R167

5.10.d: If a resident requires medication administration, unlicensed staff may administer medications under the following conditions (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of medication use."

Deficiency: "Based on staff interview and record reviews, the RN failed to develop a PRN care plan to direct unlicensed staff in the administration of PRN psychoactive medication that included all of the required regulatory components for 1 applicable resident in the sample (Resident #1)."

#1: Action to correct deficiency: Plan for the use of PRN psychoactive medication care plan revised to accommodate specific resident care planning needs. On 9/22/2014, all nursing staff was educated to the new psychoactive care planning sheets. See attached.

#2: Measures to assure this does not occur: Ensure that psychoactive medications are completed by licensed nursing staff, and that they are completed in entirety.

#3: How corrective action will be monitored: Haven/Meadows RN to monitor residents for change in condition or medication type/frequency and update care plan as needed.

Deficiency #6:

R200

5.15: Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request

Deficiency: "Based on staff interview and record review, the facility failed to produce a written policy/procedure to direct staff in the completion of the incident report process, regarding incidents reviewed for 5 of 5 applicable residents. (Residents #1, 2, 3, 4 and 5)"

#1 Action to correct deficiency: Policy and procedure completed for completion of incident reporting and process. See attached. Resident #1 has been discharged.
#2 Measures to assure this does not recur: On 9/22/14 at the nurse's meetings, it was discussed with all nursing staff the policy and procedure for follow ups to incident reporting. The medication technician and staff completing the incident report, were educated on 10/1/14 at the mandatory MT meeting about proper completion and information to report on incident reports.
#3 How corrective action will be monitored: Policy and procedure has been distributed to all staff responsible, and all new staff going forward.

Deficiency #7:

R224

6.12: Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14.

Deficiency: "Based on interviews and record review, the facility failed to ensure that each resident's right to be free from abuse was protected, based on unprovoked acts of physical aggression by 1 former resident of the SCU."

#1 Action to correct deficiency: Policy and procedure created for inappropriate behaviors of residents, as well as behavior management plans (See Attached) to manage resident to resident abuse going forward. Staff re-educated on Residents Rights at all staff meeting on 10/8/2014.
#2 Measures to assure this does not recur: Per policy and procedure, if an incident were to occur, there is a protocol in place
#3 How corrective action will be monitored: Incident reports to be completed at time of occurrence in regards to mental, verbal or physical abuse, neglect or exploitation. These reports to be reviewed with internal investigation within 24 hours of incident. HSD will review incidents for trends. All incidents/allegations will be brought up at the Quality Improvement meeting held with Executive Director, and Health Services Director present.

Deficiency #8:

R266

9.1.a: "The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment."

Deficiency: "During a tour of the Special Care Unit of the facility on 8/27/14 at 11am, it was observed that many of the heating/cooling unit covers, which protrude from the walls approximately 1.5 inches, were not securely closed, exposing extremely sharp metal clips inside the cover, posing a risk of injury to the residents with dementia residing on the Special Care Unit."

#1: Action to correct deficiency: All heat pump covers were inspected and secured with screws to prevent residents from opening covers exposing metal clips.

#2: Measures to assure this does not recur: Monthly inspection of the covers to assure the screws holding them shut are in place. Monitoring to be completed by Maintenance Director.

The Residence at Otter Creek
INCIDENT REPORTING

POLICY: The person responsible for the operation of the residence shall promptly notify the next of kin as instructed or other responsible person designated by the resident or guardian of any incident/accident or illness. All incidents/accidents occurring to residents, visitors and associates will be reported utilizing the internal incident report. State reports will also be completed as required by Regulation. Internal incident reports are proprietary in nature and used for Quality Assurance purposes.

PROCEDURE:

1. Each associate shall report to his or her supervisor all accidents and all unexpected, unintended, or undesirable incidents involving a resident, or invitee of the community.

2. All events are to be documented on the internal incident report immediately following any occurrence. The report is to be submitted to the department head for review. The department head is responsible to investigate where applicable and determine prevention for future occurrences. The completed report is to be submitted to the executive director for final review

3. The report should be filled out completely. In completing any incident report, the associate completing the report should state only the facts, not his or her personal conclusions and must adhere to the reporting requirements as outlined in this policy.

4. If a witness is present at the time of incident, a witness statement must be included in the incident report that is completed at the time of incident.

5. Responsible party to be notified. Physician notification for accidents, incidents, illness and changes in condition as required by regulation.

6. Incident reports completed, must be reviewed by appropriate supervisor within 24 hours of occurrence. If incident requires immediate medical attention, review must be completed at time of incident, as well as notification of responsible party and MD.
Incident that requires med attn
7. If incident is medical or is an inappropriate behavior (refer to Inappropriate Behaviors Policy and Procedure), a nursing assessment will be completed with complementary nurse's note as well as a service plan review.

The Residence at Otter Creek
INAPPROPRIATE BEHAVIORS

POLICY: Staff must monitor for and respond to inappropriate or difficult-to-manage behaviors in a timely manner and according to established procedure (refer to Section 7.1(b) and (c) of the Vermont Assisted Living Resident Regulations)

PROCEDURES:

1. Some residents living at the Residence may at times exhibit inappropriate behaviors (i.e., behavior that is not socially acceptable.) Such behavior may take a variety of forms. Examples of inappropriate behavior include:
   - Taking food from the plates of other residents
   - Taking dentures out and setting them on a dining table
   - Spitting out food while eating in the dining room
   - Inappropriate grabbing or touching of staff members and/or others
   - Speaking to staff members and/or others in sexually suggestive or explicit terms
   - Undressing or otherwise exposing oneself in a public area
   - Dressing in inappropriate attire in common areas (e.g. in a nightgown or underclothes)
   - Turning doorknobs, entering other residents' apartments and/or knocking on other residents' apartment doors
   - gossiping in a malicious way about other residents or staff members
   - disrupting scheduled activities at the Residence
   - Provoking arguments with other residents or with staff members

2. Inappropriate behavior may have a variety of causes and contributing factors. For example, the behavior may:
   - Be the result of Alzheimer's disease or another form of dementia. That is, the resident may not be aware of his/her behavior or may be unaware that the behavior is inappropriate.
   - Be associated with a psychiatric disorder such as schizophrenia
   - Stem from a cognitive and/or physiological impairment (e.g. from a stroke)
   - Be associated with a substance abuse problem (e.g. alcohol or drugs).
   - Be a behavior in which the resident engages to gain some form of positive reinforcement (e.g. attention from staff, family and/or other residents).

3. When resident engages in inappropriate behavior, address the behavior immediately. If the resident is alert and cognizant of his/her behavior, the Administrator should discuss the inappropriate behavior directly with the resident and explain to him/her why such behavior is not acceptable. This should be done in a manner and in a setting that will respect the privacy and dignity of the resident. Document both the behavior and ensuing conversation with the resident in his/her nurse's notes.

Adapted from Vermont Assisted Living Resident
Health Services Policy and Procedure Manual

4. If the behavior continues after the Administrator has addressed the situation with the resident, he/she should speak with the resident again regarding the behavior. If this is still unsuccessful in stopping the behavior, and staff feel that consulting the resident's family member(s)may be helpful, ask the resident for his/her permission to do so. Make appropriate documentation in the resident's nurse's notes.

5. Some residents may be unaware that their behavior is inappropriate and/or may be unable to control the behavior. In such a case, try to redirect the resident who is engaging in the behavior. Diverting the resident's attention to another activity may be effective in stopping the behavior. Document the incident in the resident's nurse's notes. Note when and what occurred, including the resident's response to the redirection.

6. If appropriate, consult with the resident's family member(s) for input and suggestions on how to handle the inappropriate behaviors. Document any conversation in the nurse's notes.

7. If a resident has demonstrated to engage in inappropriate behavior, document the behavior in the resident's Service Plan, along with techniques that have been shown to be effective in addressing the behavior.

8. If a resident consistently engages in behaviors that put him/her at risk of ridicule and/or cause embarrassment, discomfort or alarm among others, a behavior management plan should be developed and implemented (see Behavior Management Policy and Procedure)

Adapted from Vermont Assisted Living Resident
Health Services Policy and Procedure Manual

The Residence at Otter Creek
BEHAVIOR MANAGEMENT

POLICY: Develop and implement Behavior Management Plans when residents exhibit patterns of disruptive or inappropriate behaviors.

PROCEDURE:

1. Develop a Behavior Management Plan, when a resident exhibits a patter of behaviors that are disruptive to the community or inappropriate (see inappropriate behaviors policy)

2. Behavior Management Plans are typically developed when residents have some form of cognitive impairment (i.e. dementia, stroke etc), although they may also be used for residents who have other emotional difficulties (e.g. depression, anxiety or parnoia)

3. If a resident has exhibited disruptive or inappropriate behavior on a number of occasions and talking with the resident about the behavior has not been effective, a Behavior Management Plan may be indicated.

4. When developing a Behavior Management Plan, obtain input about the resident's behavior from as many sources as appropriate (e.g. staff who work closely with the resident, legal representative, family, etc.) including the resident. Try to determine if there is a pattern to the behavior and/or something that seems to trigger the behavior. For example, does the behavior tend to occur:
    - At approximately the same time each day?
    - Before, during or after similar events (e.g. birthday parties, assistance with showers, visits from a family member, etc.)?
    - When a particular person or persons are present (e.g. a certain staff member or volunteer, a family member, visiting children, etc.)

5. Observing the behavior over a period of several days and keeping a log of the behavior (s) will help staff accurately determine any patterns that are occurring may be necessary. Document such observations.

6. Write down possible patters and/or triggering events on a Behavior Management form, along with a description of the difficult behavior.

7. Obtain input from all pertinent sources (e.g. staff, family, resident, etc) on possible alternatives to break the pattern, prevent the triggering event from occurring, or at least minimize the impact of the triggering events.

8. Determine which idea(s) seem to represent the best possible solution (i.e. which alternative appears to have the closest link to the behavior). Write these down on the "Plan of Action" section of the Behavior Management Plan.

Adapted from Sample Vermont Assisted Living Residence
Health Services Policy and Procedure

9. Notify staff of the plan by incorporating all tasks related to the plan in the resident's Service Plan.

10. Document the development and implementation of the plan in the resident's nurses notes.

11. File the Behavior Management Plan in the Service Plan book behind the resident's Service Plan.

12. Monitor the resident's behavior to determine the effectiveness of the plan, documenting all observations in the resident's nurses note.

13. If a Behavior Management Plan does not produce a desired change in behavior , consult with the Division of Licensing and Protection. It may be helpful to review the Behavior Management Plan and consult with a behavior management specialist, adding any new information regarding the pattern and/or any additional alternatives.

14. If a behavior poses a risk of injury to the resident or to others, and the resident is competent to make independent decisions, entering into a Negotiated Risk Agreement as described in the Vermont Assisted Living Regulations (Sections 7.1(d) and 9.1-9.5) with the resident is required.

15. If neither a Behavior Management Plan nor Negotiated Risk Agreement is effective in reducing the severity of the behavior, the resident may need to move from the Residence if he/she no longer meets the residency criteria.

Adapted from Sample Vermont Assisted Living Residence
Health Services Policy and Procedure

BEHAVIOR MANAGEMENT PLAN

Resident Name _____ Date _____

Behavioral Concern: _____

Possible Pattern(s) to the Behavior and/or Triggering Event(s): _____

Alternatives to Break the Pattern and/or Minimize Triggering Events: _____

Plan: _____

Signature of Administrator / Manager/Designee _____ Date _____

Sample Vermont Assisted Living Residence
Behavior Management Plan

The Residence at Otter Creek
Care plan for the use of a PRN psychoactive medication

Resident Name:_____ **Month & Year:**_____
Medication Name:_____
Dosage Information:_____
Diagnosis for Prescription:_____

Side Effects of Medication:_____

The medication will be used to treat the following behaviors (select all that apply):

	Behavior represents a danger to self
	Behavior represents a danger to others
	Behavior causes resident inconsolable or persistent distress
	Behavior causes resident a major decline in function
	Behavior causes resident substantial difficulty receiving needed care

Behaviors specifically exhibited by resident:

_____
_____

Prior to administering the medication, staff will attempt at least 1 of the following interventions and document them in the care record (check all that apply):

	Taking a walk with a caregiver
	Watching TV
	Offer a snack or drink
	Try to involve in an activity or game

Interventions that resident enjoys to reduce behaviors:

_____
_____
_____

Desired Effects of Med:_____
_____

IF THE INTERVENTION(S) DO NOT WORK, THEN MEDICATION MAY BE ADMINISTERED.

Plan written by:_____ **Date:**_____

The Lodge at Otter Creek- ALF

BEHAVIOR MONTHLY FLOW SHEET , October 2014

Date Printed: 10/1/2014

Name: Location: Physician:

This form is to be used for the following medication classes: AA Antianxiety Agent AD Antidepressant AP Antipsychotic SH Sedative/Hypnotic

Med Class: Drug/Dose: Diagnosis:

A.
B.
C.
D.
E.
F.
G.
H.
I.
J.

BEHAVIOR CODE	SHIFT	ACTIVITY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	D	# of Episodes																															
	Mth Subtotal	Intervention/Drug																															
		Outcome																															
		Initials																															
	E	# of Episodes																															
	Mth Subtotal	Intervention/Drug																															
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The Lodge at Otter Creek- ALF

BEHAVIOR MONTHLY FLOW SHEET , October 2014

Date Printed: 10/1/2014 10:59

Name: **Location:** **Physician:**

This form is to be used for the following medication classes: AA Antianxiety Agent AD Antidepressant AP Antipsychotic SH Sedative/Hypnotic

BEHAVIOR Codes

1 Afraid/panic
2 Agitated
3 Angry
4 Anxiety
5 Biting
6 Compulsive
7 Continuous crying
8 Continuous pacing
9 Continuous screaming/yelling
10 Danger to others
11 Danger to self
12 Depressed withdrawn
13 Extreme fear
14 False beliefs
15 Fighting
16 Finger painting feces
17 Hallucinations/paranoia/delusion
18 Head banging
19 Insomnia
20 Jittery or nervousness
21 Kicking
22 Mood changes
23 Noisy
24 Pinching
25 Poor eye contact
26 Pulling enteral feeding tube
27 Pulling IV lines
28 Pulling urinary catheter
29 Restless
30 Scratching
31 Seeing, feeling or hearing things that are not there
32 Slapping
33 Spitting
34 Striking out/hitting
35 Suspiciousness
36 Throwing objects
37 Uncooperative
38 Wandering
39 Other: _____
40 Other: _____
41 Other: _____

Intervention Codes

1 1 on 1
2 Activity
3 Adjust room temperature
4 Backrub
5 Change position
6 Give fluids
7 Give food
8 Redirect
9 Refer to nurse's notes
10 Remove resident from environment
11 Return to room
12 Toilet
13 Other: _____
14 Other: _____
15 Other: _____
Medication: use Drug/Dose Code on page 1

Outcome Codes

I Improved
S Same
W Worsened

The Lodge at Otter Creek- ALF

SIDE EFFECTS MONTHLY FLOW SHEET , October 2014

Date Printed: 10/1/2014 11:00

Name: **Location:** **Physician:**

This form is to be used for the following medication classes: AA Antianxiety Agent AD Antidepressant AP Antipsychotic SH Sedative/Hypnotic

Med Class:	Drug/Dose:	Diagnosis:
	A.	
	B.	
	C.	
	D.	
	E.	
	F.	
	G.	
	H.	
	I.	
	J.	

MED CLASS	SHIFT	SIDE EFFECT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
AA Monthly Total	D	Code Initials																															
	E	Code Initials																															
	N	Code Initials																															
AD Monthly Total	D	Code Initials																															
	E	Code Initials																															
	N	Code Initials																															
AP Monthly Total	D	Code Initials																															
	E	Code Initials																															
	N	Code Initials																															
SH Monthly Total	D	Code Initials																															
	E	Code Initials																															
	N	Code Initials																															

The Lodge at Otter Creek- ALF

SIDE EFFECTS MONTHLY FLOW SHEET , October 2014

Date Printed: 10/1/2014 11:00

Name: Location: Physician:

This form is to be used for the following medication classes: **AA** Antianxiety Agent **AD** Antidepressant **AP** Antipsychotic **SH** Sedative/Hypnotic

Specific to Class	Code	Description
AA AD AP SH	1	Dystonia: torticollis (stiffness of neck)
AA AD AP SH	2	Anticholinegic symptoms
AA AD AP SH		a Dry mouth, blurred vision
AA AD AP SH		b Constipation, urinary retention
AA AD AP SH	3	Hypotension
AA AD AP SH	4	Sedation/drowsiness
AA AD AP SH	5	Increased falls/dizziness
AA AD AP SH	6	Cardiac abnormalities (tahycardia, bradycardia, irregular H.R, NMS)
AA AD AP SH	7	Anxiety/agitation
AA AD AP SH	8	Blurred vision
AA AD AP SH	9	Sweating/rashes
AA AD AP SH	10	Headache
AA AD AP SH	11	Urinary retention/hesitancy
AA AD SH	12	Weakness
AA SH	13	Hangover effect
AP	14	Pseudoparkinsonism:
AP		a Cogwheel rigidity
AP		b Bradykinesia
AD AP		c Tremors
AD AP	15	Appetite change/weight change
AD AP	16	Insomnia
AD AP	17	Confusion
AP	18	Akathisia:
AP		a Restlessness
AP		b Pacing
AP		c Inability to sit still
AP		d Anxiety
AP		e Sleep disturbances
AD AP	19	Tardive dyskinesia:
AP		a Lip smacking/chewing
AP		b Abnormal tongue movement
AP		c Spasmodic movement of the arms/legs
AP		d Rocking/swaying
AP	20	Blood abnormalities
AP	21	Sore throat
AP	22	Seizures
AP	23	Photosensitivity
AD	24	Suicidal Ideations
	25	Gastrointestinal disturbances
	26	Hepatic or renal abnormalities
	27	Ataxia
	28	Other:_____
	29	None